

**Comments/Questions on Maine's May 14<sup>th</sup> Response  
July 14, 1999**

**I. Requested Waivers**

1. Page 1, Question 2: The response indicates that the waiver program would assure that once individuals are deemed disabled, "they would continue SSI eligibility (excluding cash payments)". While an expansion of eligibility can be accomplished under the authority of section 1115(a)(2) of the Social Security Act, there is no authority to change the definition of disability as it relates to SSI eligibility. Please clarify your intent.

**Response:** The intent of this is to allow persons with HIV/AIDS disease to have continuous eligibility after initially becoming eligible under SSI disability rules, and allow Maine to receive federal financial participation for services provided to those individuals that would not otherwise be included as federally matchable under section 1903. This is the "Catch 21" issue, whereas once a recipient is Medicaid eligible due to disability they begin receiving the HAART regimen and probably will become well enough to lose the disability for their disease state, thereby becoming ineligible for Medicaid and not able to receive the HAART. Once begun, the continuity of treatment is of paramount importance if a successful outcome is to be achieved. Persons living with HIV/AIDS disease must have a continuity of care that is unbroken by periods of ineligibility due to the uniqueness of this disease. Continuity and effectiveness are highly related to one another, particularly when dealing with HAART regimens.

2. Page 2, Question 4: With regard to the enrollment cap request (which is still under consideration), how would participation in the demonstration project be determined? Would the 300 slots be filled on a first-come, first-served basis?

**Response:** The 300 slots would be filled on a first-come first-served basis, open to eligible persons known to the statewide HIV/AIDS network (Medicaid/ADAP/Maine Medical Aids Consultation Service, etc.).

**II. Eligibility and Enrollment**

1. Page 3, Question 1: Response A appears to include the demographic and exposure categories for people with AIDS only. Does response D include only those individuals who are HIV positive, but do not have AIDS? What are the sources of the data provided in response D and E? How complete do you estimate these data to be (i.e., do they include only data from public counseling and testing sites, for example)?

**Response:** Response D includes those who have tested positive at any site – public or private in 1998. The HIV/STD Program, Bureau of Health, Maine Department of Human Services, provided the data. Bureau of Health staff follows up on all positives and record data provided in Response E. The data is complete even though the total

numbers are relatively small.

2. Page 4, Question 1, Response F: Please explain the basis for the assertion that 1/3 of potentially waiver-eligible patients have some form of private insurance. Moreover, for those who do have private drug coverage, does Maine have any indication of how complete such drug coverage is likely to be, especially with respect to HIV-related drugs? Also, did the State account for the people with prescription drug coverage in the assumptions regarding disease progression in the absence of the demonstration? How similar to Maine's experience is the Massachusetts experience regarding the percentage of people newly entering the Medicaid program on insurance continuation?

Response: The Department has held discussions regarding the percentage of private pay, private insurance and government insurance with primary care providers throughout the state. From this informal survey it was estimated that potentially one third of the population that is eligible for the waiver would have some form of private insurance. Moreover, it was determined that only a few percent had an adequate enough pharmacy benefit for their HAART needs. This is our best estimate without conducting an extensive and expensive formal survey among Maine's health care providers.

3. Page 4, Question 1: In Response G it appears that only 24 clients are receiving protease inhibitors through the State AIDS Drug Assistance Program (ADAP). Is this correct? Are these 24 people accounted for in the assumptions regarding disease progression in the absence of the demonstration? At the top of page 6, there is a reference to an "ADAP waiting list." How many individuals are on this list?

Response: Only 24 people are receiving Protease Inhibitors through ADAP as the program in Maine has a 24-person cap. Others of the 100 total clients are receiving Protease Inhibitors through compassionate use programs. There are an additional 24 people on the ADAP waiting list.

4. Page 6, Question 4: The response indicates that some current Medicaid beneficiaries may become ineligible for Medicaid (presumably because of income or disability-related reasons) and would then be enrolled in the waiver program. If this is correct, would these individuals be given enrollment preference in the waiver program?

Response: Yes, they would be placed at the top of any waiting list and be supported by other available programs until there is an open slot in the waiver program.

5. Page 7, Question 5, Response A: The response indicates that compliance will be measured "based on the results of therapy, i.e., control of the client's HIV infection." It should be recognized that failure to control HIV infection might not always be associated with patient non-adherence but rather could indicate treatment failure. This possibility, along with other possible explanations of inability to control HIV infection, must be taken into account in assessing overall patient adherence.

Response: Concur, treatment failure and all other unsuccessful HIV infection control cases will be assessed when determining overall patient adherence.

6. Page 7, Question 6: We asked several questions regarding the definition of compliance and reasons for disenrollment. However, it is still somewhat unclear as to whether or not participants will be disenrolled due to non-compliance. The response states that “disenrollment because of lack of patient’s compliance with therapy would be a very rare event” and that a client advisory panel would help in cases where disenrollment might become appropriate. Please clearly state whether treatment non-compliance could be a reason for disenrollment. If so, please provide some examples of situations where Maine would consider disenrollment appropriate.

Response: Waiver eligibles will not be disenrolled for non-compliance, but rather poor compliance will be rapidly identified and will be intensively case managed. Optimal treatment with HAART will be the foundation for full compliance. Pharmacy edits in our system will monitor compliance of optimal drug therapy. The flags will cause immediate referral to a case manager who would contact the patient’s provider. The provider in turn would link up with the patient to work to identify the barriers to an optimal drug regimen.

7. Page 8, Question 5, Response F: Will the “decision support” system described be available to all participating Medicaid providers? What will be the source of the pharmaceutical (and other patient-relevant) data used to provide feedback to physicians and case managers—e.g., claims data information obtained from the Drug Utilization Review (DUR)? The response indicates that “pharmacists will be asked to review drug orders...” as part of the “specialized pharmaceutical edits.” Will there be a select group of pharmacists from whom HIV waiver and non-waiver participants will obtain drugs?

Response: Participating providers will be actively solicited to assist in development of reports relating to utilization of care/optimal drug management. The majority of edits will be prospective edits through MEPOPS (Maine’s point of purchase pharmacy claim system), whereas the pharmacist will be alerted, who then in turn would immediately contact the primary care provider concerning the edit. Also, there will be in place a monthly retrospective set of audits, which will be used to address issues of disease/drug interaction and medication combination issues that could not be handled prospectively.

### III. Premium Structure

1. Please provide further clarification regarding how premiums will be handled under the demonstration.

A) Will premiums be counted as an offset to the Medicaid charge, i.e., net expenditure on the HCFA Quarterly Expenditure report?

Response: Yes, the Department will create a separate account for the premium collection, and report from this account the premiums collected as offsets to expenditures.

B) Would the client pay the providers directly or would Medicaid pay the entire premium and collect the difference for the client?

Response: The premiums would be paid to the Department prior to the month of coverage and the Department would pay the providers 100% of the allowable reimbursement rate (Medicaid fee schedule where applicable). The premiums would be deposited to the account created for this purpose which simplifies the reporting on the HCFA quarterly expenditure report.

C) How would these revenues be captured on the HCFA Quarterly Expenditure reports?

Response: The revenues collected by the Department from recipients in the waiver program will go into an account created for capture in reporting expenditures. This data will be used to determine the offset to the Medicaid charges for a net expenditure in the HCFA Quarterly Expenditure Report.

#### IV. Benefit Package

1. Page 14, Question 1: In Response A-F, you indicate that hospitalization coverage was not included in the original application. Did the original budget neutrality time frame include any hospitalization services at all, even for AIDS-related conditions? Also, were there any other ways in which the originally proposed benefit package differed from the standard Medicaid benefits package? Does the 7-year budget neutrality benefit package differ in any way from the standard Medicaid benefits package? Please provide a detailed list showing the proposed benefit packages for the 5-year and 7-year budget neutrality scenarios.

Response: The original five-year model did not include any hospitalization costs for the waiver, even for AIDS-related conditions. See Appendix C of the original waiver application where the Medicaid categories of services that were provided to persons with HIV/AIDS were mapped into twelve waiver categories (based on historical Medicaid data).

The following 4 waiver categories included in the original application were drugs, laboratory/x-ray, office, and social services. Table 12 contained in Appendix C indicates the Medicaid categories mapped into the waiver categories, i.e., drugs included all drugs in the Medicaid formulary; lab & x-ray included all laboratory and x-ray tests/exams; office included general hospital outpatient, physician office, EPSDT (PHP), family planning clinics, ambulatory care clinics, RHC/FQHC visits, VD screening clinics,

Medicare B crossover, child health clinics, nurse practitioner office, and early childhood intervention; social services included community support services, licensed clinical social workers, and case management services for persons living with HIV/AIDS.

The following 8 waiver categories were **not** included in the original application were, allied health, home health, hospital, miscellaneous, nursing homes, psychology/substance abuse, residency services, BME waiver. Looking at the same table shows what these waiver categories included that were not part of the original waiver services package.

The *revised* 5-year model includes the following 5 waiver categories groupings, drugs, hospital, laboratory, office, and social services. This revised model added the hospital waiver category that includes general inpatient, ambulatory surgery center, and Medicare part A crossover.

The 7-year model would add the following 3 waiver category groupings, allied health, miscellaneous, and psychology/substance abuse. Refer to the Medicaid Categories of Service table in Appendix C of the original waiver document. Waiver category *allied health* includes podiatry, dental prosthetics, speech and hearing, physical therapy, chiropractic, occupational therapy, optometry, optical services, hearing aid dealers, audiology, speech pathology, nurse practitioner/midwife, and expanded EPSDT. Waiver category *miscellaneous* includes non-emergency transportation, supplies/DME, and ambulance. The *psychology/substance abuse* waiver category covers inpatient psychiatric facility, BMR waiver, mental health clinic services, psychology services, substance abuse services, home-based mental health, and developmental/behavioral clinic services.

2. Page 14, Question 1: You responded that the benefit package will be more inclusive than what was originally proposed and will include case management. However, you did not fully answer question 1(e) in terms of defining “case management services”. Please describe the services that constitute “case management”. Under the demonstration, is it Maine’s intent to utilize existing AIDS case management programs as providers and reimburse them on a fee-for-service basis?

**Response:** The Maine Medical Assistance Manual, Chapter II, Section 13 contains policy on Targeted Case Management Services (TCM).

Following is the Subsection regarding TCM for persons with HIV:

**“13.07CASE MANAGEMENT SERVICES FOR PERSONS WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION**

Persons with Human Immunodeficiency Virus (HIV) infection may receive case management services.

As of July 1, 1992 agencies which provide case management services will complete Rider A to their Provider Enrollment Form to certify the State share of Medicaid funding prior to billing Medicaid reimbursable services.

13.07-1 Case Management Services Eligibility Requirements for Persons with HIV Infection

A. Eligibility Requirements

A person who is infected with the human immunodeficiency virus, as determined by a positive HIV antibody or antigen test, or who has a diagnosis of HIV disease or AIDS, is eligible for services.

B. Definitions Relative to These Services

1. Antibody: A protein belonging to a class of proteins called immunoglobulins. Antibodies are produced by the body to counteract specific antigens as a response to the infection.
2. Human Immunodeficiency Virus: It is the virus which causes AIDS (Acquired Immune Deficiency Syndrome).

13.07-2 Eligibility Procedure for Persons with HIV Infection

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Designated case management agencies shall be responsible for confirming the person's eligibility for case management services. If the client is not currently receiving Medical Assistance, he or she will be referred to a regional office of the Department of Human Services, Bureau of Family Independence to determine financial eligibility for Medicaid.

If the client is pregnant and/or has given birth within the last 12 months and/or is at risk for inadequate parenting she will be referred to the nearest Perinatal Case Management Program (see 13.15).

Any release of medical records containing information on HIV infection status shall be done in compliance with 5 M.R.S.A. §19201 et. seq.

13.07-3 Covered Services for Persons with HIV Infection

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Case management services for persons with HIV infection are covered services when provided by approved staff of agencies designated by the Department's Bureau of Child and Family Services AIDS

Coordinator.

Case management services include the following:

- A. Intake and assessment. The case manager will conduct a comprehensive assessment of the client's medical, social, educational and other needs. This assessment is conducted in person and may include an evaluation of the following: general health, mental status, medication needs, self-care potential, available support network, living situation, employment status and capabilities, financial resources, support services needed, legal needs, and spiritual wishes. Appropriate health professionals will provide the necessary information for the clinical components of the assessment. Family and significant others will be consulted in the assessment, as appropriate.
- B. Development of Care Plan. The case manager will coordinate the development of a care plan, based on the assessment. The plan shall specify the services of benefit to the client, the expected duration of services, and the expected rehabilitative goals or outcome of the services. All clinical components of the plan require appropriate treatment plans (as required by appropriate licensure standards) which shall be completed, signed and dated, by the appropriate health professional. Development of the plan of care does not require direct face-to-face contact with the client.
- C. Referral/Advocacy. The case manager will assist in coordinating and mobilizing specific resources to meet the client's comprehensive service needs. The case manager will work directly with health and social service providers, community services, financial assistance, insurers, legal services and informal support systems to assure that the client has access to those services identified in the plan. Such referral and advocacy services do not require direct face-to-face contact with the eligible client.
- D. Monitoring and Evaluation. The case manager will monitor the client's status and progress in achieving the objectives of the care plan. Monitoring will be conducted with the client and by consultation with those providers of services identified in the care plan. Such monitoring does not require direct face-to-face contact with the client. The client will be evaluated quarterly for continuing eligibility for case management. The care plan will be reviewed at that time, or more frequently, if indicated. The plan

will be revised accordingly, with input from the client, and family and significant others, as appropriate. Such evaluation for continuing eligibility does not require direct face-to-face contact with the client.

#### 13.07-4 Professional and Other Qualified Staff

The Bureau of Child and Family Services (BCFS) will designate agencies to provide case management services according to criteria developed by BCFS. The Bureau of Child and Family Services' AIDS Coordinator will provide to the Bureau of Medical Services written verification that the agency is qualified to provide case management services.

Case management services may be provided by the following approved staff employed at designated agencies:

##### A. Social Worker

A social worker must hold either a Master's degree or bachelor's degree from a school of social work accredited by the Council on Social Work Education, and must be licensed in accordance with 32 M.R.S.A. §7001.

##### B. Registered Nurse

A registered nurse must have a current and valid license as a registered nurse by the Maine State Board of Nursing, and must also have appropriate professional experience in case management, as determined by the case management agency and the Bureau of Child and Family Services.

##### C. Other Qualified Staff

Other qualified staff must have a Bachelors degree or comparable experience, at least two years of case work experience, and at least one year of experience of providing services to persons with HIV infection.

#### 13.07-5 Quality Assurance

Quality assurance for case management services for persons with HIV infection will be provided by the Bureau of Child and Family Services' AIDS Coordinator and Medicaid Surveillance and Utilization Review,

Bureau of Medical Services.

The Bureau of Child and Family Services is responsible for establishing, supporting, and maintaining a quality assurance program which ensures quality case management services. This program is implemented according to Bureau of Child and Family Services policy and includes:

- A. The maintenance of records of all enrolled clients by the case management agency, according to Bureau of Child and Family Services established procedures.
- B. On-site review of sampling of active caseload. At minimum, ten percent of agency caseload will be reviewed every year.
- C. Quarterly site visits to case management agencies, to meet with case managers and provide supervision and technical assistance as necessary.
- D. Certification of staff providing case management service.”

3. Page 15, Question 3: Your response reports that the Maine DHS processes about \$6 million in claims annually and that these activities “result in an annual savings of about \$135 million.” How can such few claims processing result in such great savings? Were these figures inadvertently transposed?

Response: The final paragraph of the State’s response to the question should be corrected to the following. “The Maine Department of Human Services through its Medicaid program processes 6 million claims annually. Because of the activities of its third party team, out of the 6 million claims processed, Maine Medicaid has a resultant savings in third party liability of about \$135 million through State and Federal recovery and cost avoidance measures.”

V. Service Delivery System/Provider Network

1. Pages 16-17 question 2 and 3: Your response indicates that the provider network envisioned for this demonstration includes the “entire Medicaid provider community.” What percentage of these providers are experienced in treating HIV disease?

Response: The Bureau of Medical Services conducted a survey of its primary care providers in April and May 1999. This survey indicated that 17 primary care doctors managed the care for 353 HIV patients. Each of these 17 providers had on average about 21 patients each. These 17 doctors managed the care of 60 percent of the Medicaid HIV population.

2. Pages 16-17, Question 2: Please further explain the last sentence in the response to

Question 2. What is meant by “resources will be redistributed from acute care to chronic and preventive care”?

Response: With optimal drug management there will be less hospital utilization related to complications which can be attributed to sub-optimal drug use. Visits will become focused on the maintenance of health and achieving low viral load levels opposed to constantly putting out the fires related to complications resulting from high viral load levels and poor drug management. This is what is meant by redistribution of resources from acute to chronic and preventive care.

3. Page 17, Question 3: In the response to Question 3, it is still unclear how the State will assure that participating providers have experience treating HIV disease and managing the complex treatment regimen required. Are there any reasons to anticipate that the additional patient load created by the waiver will strain provider capacity, particularly on those providers able to treat HIV?

Response: The State will assure the experience of participating providers by the case management and referral process. During this case management process, training needs would be identified early and provided to those caregivers less experienced in HIV disease management.

Based on our conversations with HIV/AIDS providers, the only conceivable situation in which the providers would be unable to meet the demand, would be if there were no way to cap enrollment and/or control in-migration from outside Maine into the waiver program. If the program is managed as planned, the providers feel no strain will be put on their resources. The providers indicate that four well-managed waiver patients would use fewer resources than one poorly managed non-waiver patient. The opinion in the provider community suggests that the existing burdens would be lessened in a waiver program environment.

4. Page 17, Question 4: Is it true that patients will probably remain in their existing provider relationship, and thus this provider would de facto be the “assigned waiver program provider”? This would seem to assume that all patients eligible for the demonstration are in some type of contact with the health care system and have a primary care provider. This may not be the case in some circumstances, particularly for patients who are generally healthy and early in the course of infection. Will there be any special outreach to those who may not be in care?

Response: It will ultimately be the patient’s choice, expectation is that most patients would elect to remain in their existing provider/patient relationship. If a waiver enrollee has no existing primary care provider, the Department would provide a variety of provider choices based on provider’s proximity, experience, and availability. The Department’s Bureau of Health (BOH) receives information on all people whose test results indicate them to be HIV positive. When such information is reported to BOH, they conduct

outreach to connect these persons with a primary care provider, advocacy agency, and/or case management agency.

## VI. Cost Model/Budget Neutrality

1. Page 20, Introductory Notes: The State indicates that individuals who had regular use of antiretroviral therapy without another diagnosis were assumed to have symptomatic HIV infection. Given that antiretroviral therapy is currently recommended early in the course of infection, often well before symptoms appear, what is the basis for this assumption? Although treatment protocols vary, does the State have any information on the standard practice with regard to when HAART therapy is initiated in Maine?

Response: It is true that the cohort of 1996 and 1997 Medicaid clients who were on HAART therapy without another diagnosis were identified as having symptomatic HIV infection. There are two reasons for this. First, during this time period, HAART therapy was not the standard of care for people with asymptomatic HIV infection. Also, it was necessary to stratify patients into diagnostic categories from the Medicaid claims without access to the clients' clinical records. This decision was somewhat arbitrary. With regard to the present standard of care in Maine, our conversations with Maine AIDS clinicians indicate that it is the present standard of care in Maine among AIDS practitioners to start HAART therapy as early in the course of the disease as possible. This does definitely include HAART therapy in asymptomatic HIV-infected patients.

2. Page 21, Question 2: With regard to the 7-year cost model, you indicate that the without-waiver probabilities have been adjusted to reflect that 50% of clients are assumed to be on HAART without the waiver. Please explain the basis for this assumption.

Response: This isn't the case. This question is relevant to the transitional probabilities. The Waiver program is designed for clients who would not have access to HAART without the waiver. A certain proportion of those clients will, over time, become Medicaid eligible. They will then have access to HAART therapy. However, even with Medicaid, the access to HAART is complicated by the problem of spend-down. On this basis, the without-waiver transition probabilities are calculated as follows:

The proportion of clients assumed not to have access to Medicaid are assumed to have transition probabilities as stated by the Hopkins group in their pre-HAART data. The proportion of clients assumed to have access to Medicaid have transition probabilities which are half way (50%) between the Hopkins, pre-HAART probabilities and the with-Waiver probabilities.

3. Page 23, Question 5: Your response indicates that you adjusted the utilization assumptions to account for a lower rate of co-morbidity among the waiver population. How large a reduction in the expected utilization did you make using this adjustment?

Response: The issue of co-morbidity has been used in several specific places. In particular the utilization data in the asymptomatic HIV Medicaid population shows that co-morbid illnesses rather than an HIV diagnosis drive much of the hospital utilization. We would expect relatively few hospitalizations in the asymptomatic Waiver population because of HIV infection. At the same time, because the Waiver population is assumed to have less co-morbid illness than a Medicaid population, the probability is that the Waiver population will have less access to Medicare. Therefore Medicaid must bear the entire cost of hospitalization. We therefore adjusted the utilization assumption in the asymptomatic Waiver case from 0.1 PMPM to .03 PMPM, and adjusted the cost assumption from \$924 to \$2000.

4. Page 23, Question 7: There seems to be some difference of opinion as to whether new persons living with AIDS (PLWA) who would never be on Medicaid otherwise will enroll in the demonstration. It appears that the model currently assumes that no new PLWA would enroll. What is the basis for this assumption?

Response: Our latest submissions include both a constant-population model, and an open enrollment model. The former model assumes a capped enrollment and full enrollment at all times. Clients are assumed to drop the program only because of death. Additional clients enter the program up to the capped enrollment figure. These additional clients are assumed to enroll at various disease stages. The latter model estimates enrollment over the life of the program to meet the needs of all HIV-infected clients in Maine who meet Waiver eligibility criteria. This latter model includes existing Medicaid clients, clients not presently on Medicaid, and clients with all stages of HIV infection. Both models take the enrollment estimates and multiply them by PMPM calculations to derive a budget.

In the Constant Population model, the total number of new clients is taken from the estimated death rates of existing Waiver clients, with sufficient new enrollment to maintain a constant population of new patients. In the open enrollment model, the total number of clients was estimated to be 300 over the life of the program, with substantial enrollment at time zero and decreasing enrollment over time as the program better meets the needs of Maine HIV-infected people. In both cases, it is also assumed that the disease spectrum of patients will gradually shift away from patients with AIDS and toward a more asymptomatic HIV-infected population.

For cost neutrality purposes, we used the Constant-Population model.

#### **Constant Population Model:**

Waiver						
Period	Asx HIV	Sx HIV	AIDS	Dead	Total Waiver	Total with
0	150	90	60	-	300	300

1	148	91	61	2	300	302
2	146	92	62	3	300	303
3	144	93	64	5	300	305
4	142	93	65	7	300	307
5	140	94	66	9	300	309
6	138	95	67	10	300	310
7	137	95	68	12	300	312
8	135	96	69	14	300	314
9	134	96	70	16	300	316

**No Waiver**

Period	Asx HIV	Sx HIV	AIDS	Dead	Total	Total Clients
0	150	90	60	-	300	300
1	133	97	70	2	300	302
2	118	102	79	4	299	303
3	105	105	88	7	298	305
4	94	107	96	9	297	307
5	84	108	104	12	296	309
6	75	108	112	15	295	310
7	68	107	119	18	294	312
8	61	105	126	22	292	314
9	55	103	132	25	291	316

**Number of New Clients per Period**

Period	Total	Asx	Sx	AIDS
0	-	-	-	-
1	0.55	0.28	0.16	0.11
2	0.56	0.30	0.16	0.10
3	0.57	0.31	0.15	0.10
4	0.58	0.33	0.15	0.10
5	0.59	0.34	0.15	0.10
6	0.60	0.36	0.14	0.09
7	0.60	0.38	0.14	0.09
8	0.61	0.39	0.13	0.09
9	0.62	0.41	0.13	0.08

5. It is conceivable that the population that enrolls at the inception of the waiver program is likely to be, on average, at a more advanced stage of the disease than subsequent enrollees. Those enrolling in later years of the demonstration may be more recently diagnosed with HIV infection. Was this considered in your model? If so, please explain how.

Response: Both the constant-population model and the open enrollment model assume that

new clients will enter into the Waiver program at all disease stages. Both models also assume that, over time, new clients will enter into the Waiver program at earlier stages of HIV infection.

6. In order to establish a without waiver spending baseline that will help set any upper limit on the spending available for this demonstration project, it is necessary to determine the baseline Medicaid population in the HIV asymptomatic (HIVA), HIV symptomatic (HIVS), and AIDS disease categories. On the spreadsheet entitled "AIDSPTS" there is a breakdown of the people who are HIVA, HIVS or AIDS and have been on the Medicaid program at some time in 1996 or 1997. By counting the number of individuals who have been labeled "TRUE" for one of half-year time periods in 1996 or 1997, it is possible to develop the following breakdown of people on the Medicaid program:

	1 <sup>st</sup> Half 1996	2 <sup>nd</sup> Half 1996	1 <sup>st</sup> Half 1997	2 <sup>nd</sup> Half 1997
HIVA	71	63	52	51
HIVS	31	38	49	47
AIDS	126	152	151	154

Is this the complete universe of known individuals on the Maine Medicaid program during that time period? Do you agree that the above analysis is correct?

Response: The Department agrees that HCFA's analysis is exactly correct, and that this population is the complete universe of known Maine Medicaid clients with HIV infection during 1996-1997.

7. There appear to be several discrepancies in the assumptions between the waiver population worksheet (contained in the ACCESS database sent by Moe Gagnon on May 4) and Attachment 1 of the State's May 14 response. Assuming that Attachment 1 is accurate, we have several questions:

A. While roughly 50% of the national population is below 300% of poverty, it may not be the case that 50% of non-Medicaid HIV-positive people would be below 300% of poverty, either nationally or in Maine. Since conditional distributions usually become very complicated, we would like to discuss income distribution during our July meeting.

Response: This estimate was difficult to obtain. Our analysis of the random selection of 30 patients from the 180 patients of the MMC ACS shows that, out of the 30 patients, 13 were without Medicaid. 6 of those 13 patients (46%) not presently on Medicaid were estimated to be waiver-eligible. In addition, 14 out the 30 total patients (47%) were thought to be Waiver-eligible. This data drove our estimate of 50%.

B. Please explain the basis for the assumption that everyone eligible for the waiver, including those with insurance, will opt to enroll in the demonstration.

Response: Our enrollee estimates are based on worst-case analysis. If not all eligible people enroll in the Waiver program, this will cost both Maine Medicaid and HCFA less than our assumptions. At the same time, the analysis of the MMC ACS patient population took financial, social, and medical factors into consideration in arriving at the estimate of whether or not individuals would be “eligible” for the waiver.

C. What is the relationship between the AIDSPTS worksheet (from the ACCESS database) and the population table (Attachment 1). It appears that AIDSPTS was used to estimate that 250 HIV-positive individuals are presently not on Medicaid. This raises the following questions: (1) Since this estimate is based on 1997 data, would this need to be increased for an 1999/2000 estimate; and (2) the worksheet only shows around 152 Medicaid PLWA in 1997. The CDC shows about 339 total PLWA in Maine for 1997. This would suggest that only 45% of PLWA are on Medicaid in Maine. Is some other source or adjustment being used to determine the 60% estimate?

Response: The AIDSPT worksheet is mislabeled. This worksheet contains all Medicaid clients with HIV infection in 1996-1997. It makes no statements about all patients in Maine with a diagnosis of AIDS. Our estimate is also that approximately 45% of PLWA are presently on Medicaid.

D. Please provide a breakdown of the assumptions you have made regarding the following population categories. We understand some of this information may not be readily available and must be based on estimates.

	HIVA	HIVS	PLWA	Total
Total HIV in Maine				
Aware of HIV status				
Aware & not on Medicaid				
Aware & under 300% of poverty				

Response: We have not gone through the exercise of estimating all of the numbers in the supplied table. Our estimate of 300 Waiver-eligible clients was derived as shown in our May, 1999 submission.

8. How are member months defined (or counted, i.e., are the number of days of eligibility during the month prorated, is it a snapshot of eligibility on a specific day of the month, etc.)? Is the same definition of member month applied when calculating the PMPM cost? Please provide us with a computation of member months for each 6-month period of 1996 and 1997 by disease status (asymptomatic, symptomatic and AIDS). Based on an analysis of the AIDSPTS spreadsheet done by counting the total number of days on the program in 1996 and 1997, we have calculated member months counts of

2,940 (245 person years times 12) for 1996 and 2,916 (243 person years times 12) for 1997. If you agree with these figures, please provide us with your detailed computation of the appropriate counts for each year.

Response: We defined member months by adding days of Medicaid eligibility for all clients in each disease category during each time period and then multiplying the number by 12/365 to adjust member days to member months. . Our calculations show 2929 member months in 1996 and 2905 member months in 1997.

There was a small, consistent error in our calculation in that the days of eligibility were defined as last date minus first date. The proper calculation should have been (last date + 1) – first date. Therefore, each period of eligibility was understated by one day per member. The labor involved in correcting this error is substantial and the difference between the two calculations is marginal. Finally, our calculations overestimate per-member-per-month costs. The overall effect of correcting this error would be a slight decrease of Waiver program costs.

9. The intervention model relies on a very strong, effective system for coordination and care management, which is already in place. This, then, underpins the assumptions about the transition probabilities. At the July meeting, we would like to discuss the State's assumptions regarding near-perfect treatment compliance rates as it relates to transition probabilities.

Response: Our transition probabilities are based on the MMC experience. This experience is of "clinically adequate" treatment compliance as defined by rates of disease progression and viral load figures and not upon perfect treatment compliance as measured by pill counts. There has been only one death in the 180-patient MMC ACS population in each of 1997 and 1998.

10. Although you have indicated that the pharmacy discount will apply to demonstration participants and traditional Medicaid beneficiaries receiving HAART, the cost model only reflects this discount being applied to those on the waiver. Is it still the State intent to have the discount apply to both the waiver and Medicaid populations? If so, please correct the discrepancy found in the cost model.

Response: The Department and UMF has corrected our model to include the pharmacy discount for both non-Medicaid and Medicaid clients in the Waiver scenario.

11. The assumptions regarding the probability of being on Medicaid in the absence of the waiver have changed between the original application and your May 14 response, as follows:

	Original	Current
Probability of HIVA Pts Being on Medicaid	0.1	0.50

Probability of HIVS Pts Being on Medicaid	0.5	0.75
Probability of AIDS Pts Being on Medicaid	1.0	0.90

Please provide an explanation for this change. What would the costs be if the original probabilities are used? Also, please explain why they are assumed to apply immediately to Medicaid in the absence of a waiver instead of being transitioned in over time?

Response: The probabilities of Waiver population patients transitioning to Medicaid have been changed between the time of our original submission and our May 14 response based on our receipt and analysis of the MMC ACS data. It should be noted that we originally used the same probabilities of transitioning to Medicaid for both the Waiver and non-Waiver scenarios. We have subsequently added a differential factor of 10%, expecting that the Waiver program will cause fewer people to enter Medicaid than a non-Waiver scenario.

Using the constant-population model (Constant Population Cost Model tab on our spreadsheet), the original probabilities, and assuming no difference in Medicaid rates between the Waiver and non-Waiver scenarios, the 5-year waiver cost of 100 people would be \$9,320,239. The non-Waiver 5-year cost would be \$8,775,366.

The probabilities of various disease states are themselves related to time (i.e., transition probabilities carry individuals from disease state to disease state over time.) Thus, the Medicaid probabilities are related to time. This was a simplifying assumption on our part.

12. There is some difficulty in drawing a connection between the “Monthly Cost” and “Cost Model” worksheets. For example: the “Monthly Costs” shows Waiver/HIVA, HIV/Medicaid monthly cost to be \$1,222 after TPL. The “Cost Model” indicates monthly cost for the same clients to be \$1,064? Which amount is correct? This problem exists for HIVS and AIDS clients as well.

Response: The Benefits spreadsheet shows 2 different PMPM costs for the Waiver scenario for each disease state, one for clients not on Medicaid, and one for clients who have transitioned from the Waiver to Medicaid. The PMPM on the Constant Population Cost Model spreadsheet represents a blend of both PMPM’s and, in addition, includes the offset from premium payments. In the Asymptomatic state, we assume that 45% of clients will transition to Medicaid. Therefore, the equation for the blend is  $(.5) * (\text{Asx Medicaid PMPM}) + (.5) * (\text{Asx Non-Medicaid PMPM}) - (.5) * (\text{Blended Asx Premium})$ , or  $(.5) * (1222) + (.5) * (977) - (.5) * (70) = 1064$ . The same explanation applies to symptomatic and AIDS patients.

13. The “Monthly Costs” worksheet seems to incorporate the cost of medications (Anti-infective and Symptomatic treatment) twice. If so, this error is causing Totals (all categories) to be overstated. Please correct this error.

Response: The comment is correct. This error has been corrected on the Monthly Costs tab of our spreadsheet cost model. The error did not affect budget neutrality, because the overstated total was not carried forward in the model. Subsequent calculations were based on the anti-retroviral drugs, other drugs, and medical services subtotals rather than the (overstated) total.

14. A comparison of the original "Cost Model" based on 100 clients to the revised "Cost Model" based on 300 clients shows an increase in PMPM non-waiver expenditures of 59 percent (\$1,169.92 to \$1,866.00). The same comparison of waiver PMPM expenditures decreases by 5 percent (\$1,581.84 to \$1,500.00). Please explain these changes.

Response: : The PMPM figures which you cite are average PMPM's across all disease states and across clients on Medicaid and clients not on Medicaid. There are a number of assumptions which were changed between the original and revised submissions which have affected these average figures. These assumption changes include the disease spectrum of the client population, the transition probabilities, the probabilities of going onto Medicaid, the differential probability of going onto Medicaid with the presence of a waiver program, and the benefit structure of the 7-year revised submission versus the 5-year original submission.

In response to your request at our July meeting in Washington, we have added a new tab to our spreadsheet titled "Medicaid vs. no Medicaid PMPM" which details the various PMPM costs by disease state and Medicaid status.

15. A review of the worksheet addressing PMPM cost (non titled worksheet) shows waiver expenditures grow at the rate of 2.67 percent per six month period. The rate of growth for non-waiver expenditures is 9.16 percent the first six-month period and ranges from 3 to 4 percent each period thereafter. Please explain the reasons supporting the different growth rates.

Response: As noted in the answer to question 13, the PMPM figures are averages across the three disease states. Therefore, the calculated PMPM inflation rates include both the actual inflation rates of drugs and medical services as well as the increased cost of care caused by the worsening of disease state over time of the client population. Our assumption is that the waiver population is expected to be relatively more clinically stable than the non-waiver population and thus they will transition to more severe disease states more slowly. Therefore, the increase in the average cost of care of the waiver population would be expected to be lower than the increase in the average cost of care of the nonwaiver population.

There was an also an error in the number of Medicaid clients stated on the untitled spreadsheet provided with the May 13 submission, which slightly understated the expected number of nonwaiver Medicaid clients in periods 2 and above. Because the

total cost of care was correct and the PMPM was derived by dividing the total cost by the number of clients and then dividing again by 6 (months), the PMPM in the non-waiver scenario was overstated after the first period. This error explains why the non-waiver rate of growth was 9.16 between periods 0 and 1. A corrected table is shown on the following page.

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WAIVER					NON-WAIVER				
Time Period	Waiver Population	Total Waiver Cost	Waiver PMPM	PMPM Rate of Growth	Non- Waiver Population	Non- Waiver Medicaid Population	Non-Waiver Total Cost	Non-Waiver PMPM	PMPM Rate of Growth
0	300	\$ 2,699,670	\$ 1,500		300	197	\$ 2,199,931	\$ 1,866	
1	298	\$ 2,756,905	\$ 1,540	2.68%	298	201	\$ 2,359,761	\$ 1,959	5.00%
2	297	\$ 2,815,052	\$ 1,581	2.68%	296	204	\$ 2,513,460	\$ 2,051	4.69%
3	295	\$ 2,874,127	\$ 1,624	2.68%	294	207	\$ 2,661,334	\$ 2,142	4.44%
4	293	\$ 2,934,143	\$ 1,667	2.68%	291	209	\$ 2,803,671	\$ 2,233	4.23%
5	292	\$ 2,995,116	\$ 1,712	2.68%	288	211	\$ 2,940,742	\$ 2,323	4.05%
6	290	\$ 3,057,061	\$ 1,758	2.68%	285	212	\$ 3,072,808	\$ 2,414	3.90%
7	288	\$ 3,119,994	\$ 1,805	2.68%	282	213	\$ 3,200,114	\$ 2,505	3.77%
8	286	\$ 3,183,930	\$ 1,854	2.68%	279	213	\$ 3,322,895	\$ 2,596	3.66%
9	284	\$ 3,248,887	\$ 1,903	2.68%	276	213	\$ 3,441,374	\$ 2,689	3.56%
10	283	\$ 3,314,881	\$ 1,954	2.68%	273	213	\$ 3,555,760	\$ 2,782	3.48%
11	281	\$ 3,381,928	\$ 2,007	2.68%	269	212	\$ 3,666,257	\$ 2,877	3.40%
12	279	\$ 3,450,046	\$ 2,061	2.68%	266	212	\$ 3,773,056	\$ 2,973	3.33%
13	277	\$ 3,519,252	\$ 2,116	2.68%	262	210	\$ 3,876,339	\$ 3,070	3.27%
14	275	\$ 3,589,563	\$ 2,173	2.68%	259	209	\$ 3,976,280	\$ 3,169	3.22%
15	273	\$ 3,660,999	\$ 2,231	2.69%	255	208	\$ 4,073,045	\$ 3,269	3.17%
16	272	\$ 3,733,578	\$ 2,291	2.69%	252	206	\$ 4,166,793	\$ 3,371	3.12%
17	270	\$ 3,807,318	\$ 2,353	2.69%	248	204	\$ 4,257,673	\$ 3,475	3.08%
18	268	\$ 3,882,238	\$ 2,416	2.69%	244	202	\$ 4,345,830	\$ 3,581	3.04%
19	266	\$ 3,958,358	\$ 2,481	2.69%	241	200	\$ 4,431,402	\$ 3,689	3.01%

16. The “Cost Model” is based on 300 participants during the seven-year waiver period. It is estimated that 23 people will die during this period and are not replace in the cost model. Should the cost of new enrollees be addressed?

Response: We have added a feature to the model to allow for replacement of clients who die in order to keep the population constant at 300 clients. Refer to the spreadsheet, tabs “Cost Model”, and “Replacements for Deaths”

## VII. Other Concerns

1. Page 25, question 2: There was no response given to this question. Please provide a response.

Response: In general, our monthly cost estimates were derived as follows: We started with the actual, 1996-1997 average Medicaid monthly service and drug utilization and unit costs obtained from the Maine Medicaid database for the client cohorts in each disease state. Our next step was to derive a monthly Medicaid cost estimate for a Waiver-eligible population to use for the non-Waiver scenario. Next, we derived a Waiver Medicaid cost estimate for a Waiver-eligible population for those clients who had started in the (non-Medicaid) Waiver program and transitioned onto Medicaid. Finally, we derived the non-Medicaid Waiver program monthly cost estimates. (See Attachment 1, Monthly Costs tab of spreadsheet model, with attached comments.)

We have attached each of the 9 monthly cost scenarios (3 disease states, and a non-Waiver, Waiver-Medicaid, and Waiver-non-Medicaid scenario for each.) We have included a set of comments that explain the specific adjustments that have been made. In order to make the cross-reference auditing of our changes easier, we have included row and column headers on the spreadsheets.

2. Page 27, question 7: Are there privacy concerns raised by the planned uses of the data extracted and stored in Maine’s Medicaid Decision Support System (particularly with respect to “workers being able to access data through the client data extraction tool”)? Are claims data stripped of patient identifiers before being accessible by “line users (who are these line users?) as well as data analysts and report writers,” and other Bureaus, Departments, Agencies and Companies? What patient confidentiality protections are in place?

Response: Our answer to question #1, together with the 9 cost scenarios and attached comments, answers this question.

**Additional Questions for Maine HIV/AIDS 1115 Proposal  
August 12, 1999**

1. On the “Monthly Costs” tab of the State’s new 5-year model, the per capita costs differ for with the waiver and without waiver scenarios. Could the State please provide a detailed justification for each difference in costs between the two scenarios? For example, the unit cost for hospitalizations in the “Waiver/Asx HIV/NonMedicaid” category is \$2000 and it is assumed that there will be 0.03 units per month (\$64 PMPM). By contrast, hospitalization unit costs in the “Waiver/Asx HIV/Medicaid” category are \$924, but there are 0.1 units per month (\$92 PMPM). What accounts for these unit cost and units per month differences?

Response: In general, our monthly cost estimates were derived as follows: We started with the actual, 1996-1997 average Medicaid monthly service and drug utilization and unit costs obtained from the Maine Medicaid database for the client cohorts in each disease state. Our next step was to derive a monthly Medicaid cost estimate for a Waiver-eligible population to use for the non-Waiver scenario. Next, we derived a Waiver Medicaid cost estimate for a Waiver-eligible population for those clients who had started in the (non-Medicaid) Waiver program and transitioned onto Medicaid. Finally, we derived the non-Medicaid Waiver program monthly cost estimates. (See Attachment 1, Monthly Costs tab of spreadsheet model, with attached comments.)

We have attached each of the 9 monthly cost scenarios (3 disease states, and a non-Waiver, Waiver-Medicaid, and Waiver-non-Medicaid scenario for each.) We have included a set of comments that explain the specific adjustments that have been made. In order to make the cross-reference auditing of our changes easier, we have included row and column headers on the spreadsheets.

2. It appears that the per capita monthly costs on the Monthly Costs tab appear different from the Medicaid per capita cost provided by the State in the May 14<sup>th</sup> response. Could the State please explain the reason for the differences between the actual Medicaid per capita costs and the per capita costs on the spreadsheet?

Response: Our response provided to question #1, together with the 9 cost scenarios and attached comments, answers this question.

3. In the spreadsheet entitled AIDSPTS, the State provided the breakdown in 1996 and 1997. It would be very helpful to know how these HIV+ people became eligible for Medicaid. Could the State please provide a detailed breakdown of the eligibility categories of the eligibility categories for HIV+ Medicaid population?

Response: The two spreadsheets below identify the 1996 and 1997 eligibles used in the AIDSPTS spreadsheet.

### 1996 HIV Eligibles

MMIS Code	Program Description	Number	Percent
74	NOT RECEIVING AFDC DEPRIVED NOT ELIGIBLE	1	0.17%
16	AFDC CHILD CONTINUOUS COVERAGE	1	0.17%
2E	BOARDING HOME-FEDERAL	1	0.17%
53	COST REIMBURSEMENT BOARDING HOME	1	0.17%
31	MEDICAL EYE CARE	1	0.17%
10	NON-TITLE XIX - FOSTER CARE (SW)	1	0.17%
64	NURSING HOME RESIDENT INCOME 100-300% DISABLED	1	0.17%
63	NURSING HOME RESIDENT INCOME UNDER SSI DISABLED	1	0.17%
1A	SOBRA AGED	1	0.17%
1B	SOBRA CHILD	1	0.17%
1E	SOBRA PREGNANCY	1	0.17%
1	SSI AGED	1	0.17%
71	UNDER 21, LOW INCOME, DUE DISREGARD STEP	1	0.17%
81	STATE 45 DAY OPENINGS	1	0.17%
47	HAD SSI BUT ELIGIBLE PICKLE DISABLED	2	0.34%
15	AFDC ADULT CONTINUOUS COVERAGE	2	0.34%
55	NURSING HOME RESIDENT, INCOME UNDER SSI AGED	2	0.34%
56	NURSING HOME RESIDENT, INCOME 100 - 300% AGED	2	0.34%
29	ALPHA WAIVER DISABLED	2	0.34%
2D	TRANSITIONAL CHILD CARE	2	0.34%
2U	DISABLED ADULT WAIVER	2	0.34%
11	FOSTER CARE - CHILD WELFARE (CW)	2	0.34%
5	AFDC CHILD UNER 21	5	0.85%
3E	BOARDING HOME - STATE SUPPLEMENT ONLY	5	0.85%
70	UNDER 21, LOW INCOME, DEPRIVED	5	0.85%
80	STATE DELAY, RHODES VS PETIT	6	1.02%
1K	HOME BASED CARE AND SPECIAL NEEDS - ADULT	7	1.19%
93	SSI DISABLED/INELIGIBLE HH	8	1.36%
1M	CHILD PROTECTIVE CASE	19	3.22%
4	AFDC ADULT	24	4.07%
20	NOT ELIGIBLE SSI, BUT SPEND-DOWN DISABLED	25	4.24%
1U	WEET ELIGIBLE	26	4.41%
46	NO SSI BUT ELIGIBLE DISABLED	44	7.46%
3D	DISABLED - STATE SUPPLEMENT ONLY	45	7.63%
1V	MEDICAID AND QMB	45	7.63%
1C	SOBRA DISABLED	71	12.03%
3	SSI DISABLED	<u>225</u>	<u>38.14%</u>

# 1997 HIV Eligibles

MMIS Code	Program Description	Number	Percent
1A	SOBRA AGED	1	0.17%
53	COST REIMBURSEMENT BOARDING HOME	1	0.17%
15	AFDC ADULT CONTINUOUS COVERAGE	1	0.17%
1	SSI AGED	1	0.17%
1E	SOBRA PREGNANCY	1	0.17%
47	HAD SSI BUT ELIGIBLE PICKLE DISABLED	2	0.34%
2U	DISABLED ADULT WAIVER	2	0.34%
29	ALPHA WAIVER DISABLED	2	0.34%
67	NOT RECEIVING AFDC, BUT ELIGIBLE	2	0.34%
16	AFDC CHILD CONTINUOUS COVERAGE	2	0.34%
1D	SOBRA NEWBORN	2	0.34%
80	STATE DELAY, RHODES VS PETIT	2	0.34%
62	NURSING RESIDENT, ZERO INCOME, DISABLED	2	0.34%
10	NON-TITLE XIX - FOSTER CARE (SW)	3	0.50%
56	NURSING HOME RESIDENT, INCOME 100 - 300% AGED	3	0.50%
81	STATE 45 DAY OPENINGS	3	0.50%
3E	BOARDING HOME - STATE SUPPLEMENT ONLY	3	0.50%
2D	TRANSITIONAL CHILD CARE	3	0.50%
70	UNDER 21, LOW INCOME, DEPRIVED	4	0.67%
11	FOSTER CARE - CHILD WELFARE (CW)	5	0.84%
5	AFDC CHILD UNER 21	5	0.84%
93	SSI DISABLED/INELIGIBLE HH	8	1.34%
1K	HOME BASED CARE AND SPECIAL NEEDS - ADULT	15	2.52%
20	NOT ELIGIBLE SSI, BUT SPEND-DOWN DISABLED	15	2.52%
4	AFDC ADULT	17	2.86%
1M	CHILD PROTECTIVE CASE	20	3.36%
1U	WEET ELIGIBLE	23	3.87%
46	NO SSI BUT ELIGIBLE DISABLED	30	5.04%
1V	MEDICAID AND QMB	57	9.58%
3D	DISABLED - STATE SUPPLEMENT ONLY	66	11.09%
1C	SOBRA DISABLED	86	14.45%
3	SSI DISABLED	208	34.96%